ATTACHMENT 3

- The investigative record did not include any information related to the investigator's decision to change the final disposition of the allegation of Physical Abuse from Inconclusive to Unconfirmed.[53] Because the investigator was unable to obtain information that confirmed when and how the child sustained the injury, the allegation of Physical Abuse should have been assigned a disposition of Inconclusive.

With regard to the allegation of Neglect, the Monitors also find the investigation was deficient. The investigative record raises the same critical concerns highlighted in the above investigations (most notably, IMPACT IDs: 48632744 and 48646196): namely, that Educare failed to train and support the single, on-duty staff member (Staff 4) to adequately care for Child A. Due to these failings, Staff 4 was unable to effectively intervene to protect Child A and other residents when Child A's behavior escalated on the date of the alleged incident. The responding law enforcement officer to the incident reported that Staff 4 "could not control" Child A and that the group home appeared "understaffed." Similar to other investigations, the investigator again failed to discuss or further explore whether Educare administrators had failed to "provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff" resulting in or creating risk of physical or emotional injury or death for this child.[54]

Finally, when Child A entered the hospital on April 30, 2021, Educare discharged the child from its care. According to a physician who treated Child A at the hospital, staff members brought the child to the hospital with her all of her belongings.

Notable Gaps in Investigation Timeframe:

The investigation took four months to be completed. The intake was received on May 4, 2021. An extension was approved on June 14, 2021, with documented reasons of "Extraordinary Circumstances" and "More time is needed to identify and interview collaterals, company has not provided requested information." The investigation was completed on September 2, 2021, approved on September 2, 2021, and closed on November 3, 2021.

Child C, age 14-15, IQ Unknown

The monitoring team reviewed 12 investigations into abuse or neglect of Child C (age 14-15) while she was placed at C3 Academy, LLC, an HCS Group Home. Eleven of the investigations resulted in an overall disposition of Unconfirmed or Inconclusive; in one investigation of Physical Abuse, PI entered a disposition of Confirmed for the allegation that a staff member physically abused Child C when she tasered the child.

Child C was placed at C3 Academy for one year from April 4, 2021 to May 4, 2022. According to Child C's Plan of Service, Child C is diagnosed with: Unspecified Disruptive Behavior Disorder; Language Disorder; ADHD-Combined Presentation; and Intellectual Disability-Mild (provisional). Child C's Full-Scale IQ is unknown because she was unable to participate in IQ testing.

As the following table shows, PI opened ten of the 12 investigations related to allegations of abuse and neglect of Child C between May 24, 2021 and November 7, 2021. The last two investigations

[53] The monitoring team did not locate any supporting documentation for this investigation in PI's external storage database, NeuDocs.
[54] *See* 26 TEX. ADMIN. CODE §711.719(b)(3).

opened in April 2022, with the final investigation opening on April 28, 2022 after a staff member dropped Child C off at a hospital with a broken jaw. The 12 investigations involved six unique alleged perpetrators, two of whom were involved in more than one investigation. PI did not complete all of the investigations until March 20, 2023, with the longest investigation spanning 19 months prior to completion. Due to substantial delays in PI's completion of these investigations, Child C was no longer placed at C3 Academy when these investigations closed.[55]

Table 2: PI Abuse or Neglect Investigations of Child C

Case ID	Intake Date	Completed Date	Closed Date	Months open prior to Completion	Allegation Type	Alleged Perpetrator
48677387	5/24/2021	10/15/2022	10/17/2022	16+ months	Physical Abuse	Staff 1
48746511	7/19/2021	1/26/2023	1/30/2023	18 months	Neglect	Staff 2
48769719	8/7/2021	1/26/2023	1/30/2023	17 months	Neglect	Unknown
48777670	8/13/2021	1/26/2023	1/30/2023	17 months	Neglect	Staff 2
48785934	8/20/2021	3/20/2023	3/21/2023	19 months	Neglect	Staff 3
48797313	8/29/2021	1/27/2023	1/30/2023	17 months	Neglect	Staff 2
					Physical Abuse	Staff 2
48794924	8/26/2021	2/7/2023	3/24/2023	17 months	Physical Abuse	Staff 3
48801178	9/1/2021	2/7/2023	4/13/2023	17 months	Neglect	Staff 4
					Physical Abuse	Staff 4
					Physical Abuse	Staff 3
48846045	10/2/2021	1/27/2023	1/30/2023	16 months	Neglect	Staff 3
					Physical Abuse	Staff 3
48896408	11/7/2021	12/21/2022	12/23/2022	13 months	Sexual Abuse	Staff 2[56]
49096014	4/6/2022	1/27/2023	1/30/2023	9+ months	Physical Abuse	Staff 5
49131249	4/28/2022	2/7/2023	4/13/2023	9 months	Physical Abuse	Staff 6

In eleven of the 12 investigations, the investigator requested and received an extension; however, there is no documentation in the record to explain the delays or reasons for the extensions. The monitoring team identified that these significant investigative delays and egregiously deficient investigations left Child C at great risk of harm while she continued to be placed at C3 Academy. The State's lack of action on behalf of Child C and the decision to have her remain in the care of this entity is confounding in the face of these allegations.

The investigative records included the following dangerous investigative practices in the face of serious allegations of abuse and neglect of Child C: an overarching failure to prioritize and take into account the child's safety needs at all times; failure to timely and adequately interview Child C, if at all, particularly considering her documented speech and comprehension limitations; and

[55] Child C is currently placed at a State Supported Living Center. As of September 1, 2023, Child C is an alleged victim in three open investigations into allegations of Sexual Abuse and Physical Abuse. She is also an alleged victim in three additional investigations in her current placement that opened between June 11, 2023 and July 16, 2023 and closed with dispositions of Unconfirmed.

[56] According to IMPACT, the investigator did not formally assign a named alleged perpetrator to this investigation. However, within the investigative record, the investigator named Staff 2 as the alleged perpetrator.

unexplained investigative delays of over a year that significantly impeded the quality and quantity of information investigators gathered to assess whether the child had suffered abuse or neglect. In many instances, the failure to pursue the allegations for months at a time displayed an abject indifference to child safety. Further, as described more fully below, in addition to the deficiencies identified by the monitoring team within each of the individual investigations, HHSC and its investigators also failed to appropriately coordinate their work among investigations involving Child C and her repeated outcries and reports of abuse and neglect. This and other critical lapses in investigative practice left Child C at serious risk and, ultimately, allowed for further harm to occur to the child.

The State's unexplained and extensive delays and inactivity turned a deaf ear to Child C's repeated outcries of abuse or neglect across investigations. As a result, the State did not identify patterns and concerns related to Child C's care while placed at C3 Academy, which began with an incident of confirmed Physical Abuse when the child was tasered by a staff member and culminated one year later when Child C suffered a broken jaw from Physical Abuse that PI should have Confirmed. Due to these failures, PI investigators did not appropriately investigate nor mitigate risk of harm to Child C following allegations of abuse or neglect at C3 Academy. Moreover, HHSC conducted the investigations with an utter and shocking disregard for child safety.

Confirmed Physical Abuse of Child C

7. IMPACT Case ID: 48677387

Summary of Key Allegations and Monitors' Review:

On May 24, 2021, six weeks after Child C was placed at C3 Academy, PI initiated its first investigation (IMPACT ID: 48677387) of Physical Abuse of Child C by a named staff member.

Assigned Priority and Disposition:

Significantly delayed, PI completed the Priority One investigation nearly 17 months later on October 15, 2022 with a disposition of Confirmed and found a preponderance of evidence that a staff member tasered Child C on her arm while she was in bed:

> Testimony from [Child C] supports that [Child C[57]] identified [Staff 1] by name and that [Staff 1] held a taser to [Child C's] inner left forearm multiple times. Photographs of [Child C's] inner left forearm support there were burn, signature or taser marks. Testimony from Officer [name removed] supports that after review of the photographs of [Child C] by Officer [name removed] that he could confirm the marks were signature marks or burn marks from a taser and it looked like when someone would touch a taser to skin and the person would pull away and then the taser would be touched again to the skin harder. Although a taser could not be recovered, Incident/Investigation Report supports that at one point [Staff 1] did have a taser even though she had not seen it since December of 2020.

[57] The investigator wrote Staff 1 in this location of the text, not Child C. This appears to be a typo.

As of September 1, 2023, the staff member is not registered on the Employee Misconduct Registry where such instances are confirmed for future employers.

Monitors' Review:

As noted below in the investigation timeline, there is no documentation in the record to explain the extensive delay nor the lack of investigative activity for more than thirteen months. The investigation incorporated evidence from law enforcement's criminal investigation but there is no indication in any of the records that the investigative delay was caused by such coordination with law enforcement. The significant delay in the resolution of these serious allegations as eleven new investigations emerged naming this child as an alleged victim, evidences a profound failure to conduct the investigation consistent with the child's safety needs as required by Remedial Order 3.

During Child C's interview, the investigator used an American Sign Language (ASL) interpreter due to Child C's documented limited speech. With the assistance of the interpreter, Child C used some signs, gestures, and language to communicate to the investigator that Staff 1 held something against her forearm twice and that it hurt; the investigator ultimately determined that the object the staff member used on Child C's arm was a taser. As discussed in the following investigations involving Child C, investigators routinely failed to accommodate Child C's limited speech through methods such as an ASL interpreter; this failure in subsequent investigations may have reduced the child's ability to communicate and report allegations of abuse or neglect during her subsequent interviews with investigators.[58]

Notable Gaps in Investigation Timeframe:

The investigation took one year and four months to be completed. The intake was received on May 24, 2021. An extension was approved on June 25, 2021, with a documented reason of "Other: Need to interview collaterals and alleged perpetrator." The investigation was delayed without activity between June 2021 and August 2022. The record did not include any explanation for the lack of investigative activity for more than thirteen months and substantial delay in completing the investigation. The investigation was completed on October 15, 2022, approved the same day on October 15, 2022, and closed on October 17, 2022.

Following the Physical Abuse of Child C by a staff member using a taser, Child C remained at the C3 Academy for ten additional months and was identified as an alleged victim in 11 other investigations. Of those additional investigations, six included further allegations of Physical Abuse of Child C. PI failed to appropriately investigate these allegations and, as a result, did not safeguard Child C's safety. In two of the investigations, the monitoring team disagreed with PI's finding of Inconclusive, instead finding that the investigative records included a preponderance of evidence of Physical Abuse or Neglect. In the first investigation, the record showed that a staff member neglected Child C when he locked the child and another adult resident in a bedroom at night and left the premises, and in the second investigation, the record showed that a different staff

[58] Child C's records indicate that she has varying communication capacities, including some ability to speak in short sentences and answer questions. To accommodate Child C's communication, the child's record documents that she has "some sign language" and that a communication board was requested for her "as she is not able to fully communicate." It is not evident from the records that Child C was provided a communication board nor that any PI investigators considered the use of such a tool to encourage Child C's ability to report information to investigators to safeguard her safety.

member physically abused Child C by breaking her jaw. In all other instances, the investigations were substantially deficient.

Unconfirmed and Inconclusive Allegations of Abuse or Neglect of Child C

8. IMPACT Case ID: 48746511

Summary of Key Allegations:

On July 19, 2021, two months after a staff member used a taser on Child C's left forearm in a manner consistent with it being "pulled away and…touched again to the skin harder," a law enforcement officer reported an allegation of Neglect of Child C at C3 Academy. The reporter stated that Child C ran away from the placement. After law enforcement located and returned the child to her placement on the same day, the child allegedly attempted to strangle herself by placing a sheet around her neck. According to the officer, the child stated that she was trying to kill herself and that she wanted to be admitted to a hospital.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect investigation related to Child C by a named staff member, Staff 2. Due to substantial investigative deficiencies, most notably the 18 months to complete the investigation, a disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed.

Monitors' Review:

The investigator did not attempt to gather sufficient evidence to determine whether Staff 2 adequately supervised Child C at the time of the incident. The investigator conducted a face-to-face interview with Child C eight days after PI received the intake with the assistance of an ASL interpreter. During her interview, Child C reported that she ran away from the group home and wrapped a sheet around her neck in response to verbal and physical altercations with other residents in the home. Following this interview, the investigator did not conduct any additional investigative activity for 18 months, during which time the investigation alleging another staff member tasered the Child also remained open.[59] Once the investigation resumed a year and a half later, and nine months after Child C had been moved from the HCS Group Home, the investigator identified the staff member responsible for Child C's supervision at the time of the incident but did not attempt to interview this key individual. The investigator also did not attempt to identify and interview any other staff members or other residents who may have been present on the day that the child attempted to kill herself.

The investigator interviewed the responding law enforcement officer to the incident; the officer reported that the staff member contacted law enforcement promptly after Child C eloped and responded appropriately when Child C attempted to place the sheet around her neck. Although the law enforcement officer and Child C did not appear to report any concerns for Neglect to the investigator, the investigator did not assess whether the staff member appropriately supervised

[59] PI closed the investigation involving a staff member tasering Child A nearly 17 months after it was initiated in October 2022 and three months before the instant investigation (IMPACT ID: 48746511) closed in January 2023.

Child C prior to her elopement. Moreover, the investigator failed to determine whether staff members took appropriate actions to minimize, address, or contain any verbal or physical altercations between Child C and the other residents or whether supervisory failures contributed to the conflicts in other ways. Because the investigator did not interview key individuals involved in the alleged incident, including the alleged perpetrator, the investigator failed to gather sufficient evidence to determine whether the alleged perpetrator neglected Child C prior to her elopement.

Notable Gaps in Investigation Timeframe:

The investigation took one year and six months to be completed. The intake was received on July 19, 2021. An extension was approved on November 2, 2021, with a documented reason of "Need to talk to collaterals, Ap, request documentation and police report." The investigation was delayed without activity between July 2021 and January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 26, 2023, approved the same day on January 26, 2023, and closed on January 30, 2023.

9. IMPACT Case ID: 48769719

Summary of Key Allegations:

On August 7, 2021, nearly three weeks after SWI received the above intake report, a law enforcement officer reported that he responded to another incident of Child C eloping from the placement. According to the reporter, law enforcement observed Child C running down a busy street and a staff member was running after her. The reporter expressed concern that Child C was a "flight risk" and that the staff members at the placement may not have provided adequate care for her. The reporter noted that other residents had allegedly wandered off "unnoticed" from the placement. Lastly, the reporter stated that he observed marks on Child C's arm, but he did not know whether the marks were injuries.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect investigation related to Child C by an unknown staff member, which became its third open investigation involving Child C. Due to substantial investigative deficiencies, most notably the 17 months to complete the investigation, a disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed.

Monitors' Review:

The investigator did not gather sufficient evidence to render a disposition regarding the allegation of Neglect of Child C. First, the investigator attempted to interview Child C three days after the date of the intake report while the child was hospitalized;[60] the child was asleep when the investigator arrived at the hospital to conduct the interview. The investigator documented that she observed Child C asleep in the emergency room with a blanket over her and that she did not observe any marks or bruises on the child, presumably because the blanket covered the child's

[60] The Monitors could not determine why the child was hospitalized from the available records.

body. The child returned to the placement after a few days in the hospital; the record did not document the length of her hospital stay and the investigator did not attempt to interview Child C again, at the hospital nor at the group home.[61] In the absence of interviewing and adequately observing the child, the investigator failed to assess the child's safety and gather information about the allegation, particularly given the reporter's observation that the child had marks on her arms and was not receiving adequate care at C3 Academy, in addition to pending allegations she had been tasered by a staff member nine weeks earlier, had eloped previously, and had then tried to tie a sheet around her neck. Following the attempted visit with Child C, the investigator did not pursue any additional investigative activity for 17 months and, shortly thereafter, closed the investigation with a disposition of Unconfirmed. The investigator concluded the investigation without identifying and interviewing an alleged perpetrator or any other staff members who may have been present on the day of the alleged incident. Finally, the investigator did not consider highly relevant information about the allegations, including reports by a law enforcement officer that residents wandered off from the property "unnoticed." The investigator did not consider whether the group home's referral history included similar allegations that the group home failed to provide adequate care to and supervision of children;[62] as noted previously, a review of those patterns is not part of PI's practice unless it involves the same alleged perpetrator or victim.

Because the investigator did not gather any evidence related to the allegations, including a failure to communicate with the child, the assigned disposition of Unconfirmed to the allegation of Neglect is baseless and inappropriate.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed and there was no approved extension.[63] The intake was received on August 7, 2021. The investigation was delayed without activity from August 2021 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 26, 2023, approved on January 26, 2023, and closed on January 30, 2023.

10. IMPACT Case ID: 48777670

Summary of Key Allegations:

Nearly a week after law enforcement reported the above allegations (IMPACT ID: 48769719), on August 13, 2021, a different law enforcement officer reported another allegation of Neglect of Child C at C3 Academy. The law enforcement officer reportedly spoke to Child C while she was admitted to a hospital (a different hospital stay from the one referenced above, during which time the investigator failed to return to interview the child). The child was hospitalized after she allegedly jumped out of a van and attempted to tie sheets around her neck for the second time in

[61] While a separate investigation of Neglect during this time-period referenced a visitor suspension at C3 Academy due to COVID-19, there is no such documentation in this record explaining why the investigator never spoke to nor fully observed the child in-person or through other means.
[62] *See e.g.*, DFPS, *Preponderance of the Evidence*, 1, 5 (undated training manual) (on file with the Monitors).
[63] IMPACT shows that the investigator requested an extension on September 9, 2021; however, it appears that a supervisor did not approve this extension.

approximately four weeks. Child C disclosed to the law enforcement officer that she was punched a lot at her placement. The law enforcement officer observed a laceration near the child's right eye. The child then reported that a named resident (Individual 1, age 20) punched her and she bled a lot. The child reported that she did not receive medical care for the injury to her eye.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect investigation related to Child C by a named staff member, Staff 2, which became its fourth open investigation regarding Child C. Due to substantial investigative deficiencies, most notably that it took 17 months to complete the investigation, a disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed.

Monitors' Review:

Due to a substantially delayed investigation and missing interviews with key individuals, the investigator failed to determine the following information to inform the disposition.

- Whether Staff 2 adequately supervised the child to prevent or mitigate the child from jumping out of the van and whether the staff member promptly notified law enforcement following her exit from the van;

- Whether Staff 2 adequately supervised the child prior to her tying a blanket around her neck for the second time in four weeks: and,

- Whether the child's injury near her eye was due to a lack of supervision.

First, the investigator interviewed Child C by video call using the application FaceTime.[64] The investigator did not document any efforts to accommodate Child C's limited speech during the interview; in two other investigations, the record documented that PI conducted the interview with the assistance of an ASL interpreter and it is unclear how this investigator determined that she could ensure Child C's meaningful participation in the video interview without aid. During her interview, Child C reported to the investigator that she jumped out of the van because Staff 2 poured out her soda. Child C also reported that Individual 1[65] scratched her and caused her lip to bleed, as she alleged in the intake report. During the video call, the investigator reportedly took screenshots of the child; the investigative record did not document whether the screenshots were of the child's face nor did the investigator document whether she observed any injuries on the child. When interviewed shortly after Child C, the case manager at C3 Academy reported that she was unaware of any incidents between Individual 1 and Child C. Regarding Child C's elopement, the case manager reported that after the child jumped out of the van, the child ran into someone's backyard and jumped into their pool. Reportedly, Child C knew how to swim and was able to safely exit the pool by herself. After an unknown duration of time had passed, a law enforcement officer located the child and returned her to C3 Academy. Once she returned to the placement and

[64] According to the investigative record, the group home case manager reported that the placement suspended visitors due to the COVID-19 pandemic.
[65] According to a C3 administrator, Individual 1 had previously been incarcerated for assaulting his mother.

law enforcement was still present at the facility, the child attempted to tie a sheet around her neck in another room at the home. When the staff member checked on the child after an unknown period, he reportedly intervened and removed the sheet from the child's neck. According to the police report, after the child "wrap[ped] a bed sheet around her neck and state[d] that she wanted to kill herself," a law enforcement officer placed Child C under an "emergency detention and into double lock handcuffs." Law enforcement then transferred Child C to a hospital. At the time of this incident, the child was subject to "routine" supervision.

After completing initial interviews with Child C and the case manager, the investigator did not pursue any investigative activity for one year and five months. After this significant delay, and several months after the child was moved from the placement, the investigator attempted to locate the alleged perpetrator (Staff 2) and Individual 1 for interviews. Likely due to the significant delay, the investigator was unable to locate and interview these key individuals. The investigator then re-interviewed the case manager who reported that she did not recall the details surrounding the alleged incident. The investigator also interviewed the responding law enforcement officer at this delayed time. She reported similar information to the investigator as contained in her initial intake report that was made nearly a year and a half prior.

Due to these deficiencies, the investigator failed to gather sufficient information to render a disposition for the allegation of Neglect.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on August 13, 2021. An extension was approved on October 29, 2021, with a documented reason of "Additional interviews needed with collateral and alleged perpetrator." The investigation was delayed without activity from August 2021 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 26, 2023, approved on January 26, 2023, and closed on January 30, 2023.

11. IMPACT Case ID: 48785934

Summary of Key Allegations:

During a nine-week period between August 20, 2021 and October 28, 2021, SWI received eight reports of Physical Abuse regarding an adult resident (Individual 2, age 29) at C3 Academy which PI merged together into a single investigation that eventually involved Child C as an alleged victim, as well. The reporters, including a law enforcement officer, medical facility staff, and Individual 2's service coordinator, reported that Individual 2 stated a staff member (Staff 3) "punched," "beat up," "assaulted," and "hit" her on her arms and face and that she had injuries as a result.

Assigned Priority and Disposition:

Child C was not named in any of the initial allegations; however, a PI investigator added her as an alleged victim after initiation of the Priority Two investigation. During an interview on August 24, 2021, Individual 2 relayed that she and another adult living in the home (Individual 3, age 18)

engaged in a physical altercation with Child C while Staff 3 drove them in a van on two occasions. Individual 2 also alleged that Staff 3 "punched" her in the van after she fought with Individual 3 and Child C.

Due to substantial investigative deficiencies, most notably that it took 19 months to complete the investigation, a disposition of the Neglect allegation related to Child C by Staff 3 cannot be determined. The investigator assigned the allegation a disposition of Inconclusive.

Monitors' Review:

Regarding the allegation of Neglect involving Child C, the investigative record demonstrated the following critical deficiencies. First, the investigator never interviewed Child C about the allegations related to her. Second, the investigator failed to interview the alleged perpetrator; having waited 18 months to attempt the interview, the investigator was unable to locate him. Finally, the interviews that did occur with the adult alleged victims, Individuals 2 and 3, failed to include sufficient questioning (if any) about the physical altercation related to the alleged victimization of Child C and one of them was conducted three months after PI received the intake.

As noted above, the investigator did not conduct an interview of Child C related to the allegations contained in this investigation. Instead, the investigator included in the investigative record an interview that was conducted with Child C on September 1, 2021 for a separate investigation (IMPACT ID: 48801178, discussed below) regarding unrelated allegations made by law enforcement on a later date; that report alleged that a different staff member locked Child C in a bedroom with Individual 2 in the home and left the premises. During that interview attempt in the other investigation, Child C was reportedly unwilling to speak to the investigator about the allegations of abuse and neglect in that investigation. The investigator did not attempt to interview Child C about the allegations contained in the instant investigation and, therefore, the investigator did not gather any information from Child C about the allegation under investigation in this investigation.

Individual 2 stated during her interview that she engaged in a physical altercation with Child C while Staff 3 transported them in a van on two specified dates; however, it appears that the investigator never asked Individual 2 to describe the physical altercation. As a result, the nature and severity of the alleged altercation between the two adults and Child C is unknown. When the investigator interviewed Individual 3 approximately three months after the date of this intake report, the investigator did not document that she asked Individual 3 any questions related to the alleged physical altercations in the van. Finally, when the investigator attempted to locate Staff 3 18 months after the investigation opened, the contact person at the placement reported that the alleged perpetrator was no longer employed there. Staff 3 did not respond to the investigator's delayed attempts to interview him. Due to these critical deficiencies and a severely flawed investigative approach, the investigator gathered almost no information about the allegation related to Child C and the disposition of Inconclusive for the allegation of Neglect is baseless and inappropriate.

Notable Gaps in Investigation Timeframe:

The investigation took one year and seven months to be completed. The intake was received on August 20, 2021. An extension was approved on September 21, 2021, with a documented reason of "Additional interviews and documentation needed." The investigation was delayed without

activity from December 2021 to March 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on March 20, 2023, approved on March 21, 2023, and closed on March 21, 2023.

12. IMPACT Case ID: 48797313

Summary of Key Allegations:

On August 29, 2021, two weeks after the initial intake reports were received by SWI for the investigation above, a social worker at a hospital reported allegations of Physical Abuse and Neglect of Child C at her placement. According to the reporter, Child C reportedly ran away from the placement and law enforcement located her within an hour of her elopement. The child allegedly informed law enforcement that she wanted to kill herself with a knife. According to the reporter, the child stated that she ran away from the placement because an unnamed staff member at the facility hit her. (At this time, there were five separate investigations opened regarding allegations of Physical Abuse and/or Neglect of Child C, with both distinct and similar allegations). After law enforcement located Child C, they transported her to a hospital where she was seen by a psychiatrist. The psychiatrist observed Child C to be "extremely dirty," not wearing underwear, with feces in her pants, and allegedly "had not eaten all day." Reportedly, the psychiatrist did not observe any injuries on the child's body that were consistent with a staff member hitting her; however, the psychiatrist observed that the child had "lots" of scarring on her body due to self-injurious behavior.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect and Physical Abuse investigation related to Child C by a named staff member, Staff 2, which became its sixth open investigation involving allegations of Physical Abuse or Neglect of Child C. In its investigative findings 17 months later, PI entered a disposition of Unconfirmed for the allegation of Neglect and a disposition of Inconclusive for the allegation of Physical Abuse. Due to substantial investigative deficiencies, a disposition for the Physical Abuse and Neglect allegations related to Child C cannot be determined.

Monitors' Review:

During her face-to-face interview with the investigator, Child C confirmed that a staff member hit her and added that the staff member hit her on the arm. When the investigator asked who hit her, the record states that the child pointed toward "the staff" who was present in the home. The investigator did not document in the investigative record which staff member(s) the child identified. Next, the investigator asked the child how she obtained the scratches on her face. The child responded that she got into a fight and pointed to another individual in the home. Again, the investigator did not document who the child identified when she pointed. The investigator documented that she attempted to ask Child C additional questions, but the child did not respond. Based upon the investigative record, it is unclear whether the child no longer responded to the investigator's questions due to her limited speech and comprehension. The investigator did not

make any efforts to accommodate Child C's limited speech and comprehension during the interview.

The investigator did not appear to consider whether Child C's allegation that a resident scratched her was related to the allegation included in the above investigation with an intake date of August 13, 2021 (IMPACT ID: 48777670); as noted above, a different investigator conducted a deficient investigation in that instance, as well. It is also unclear whether the scratches the investigator observed on the child's face in the current investigation were related to or separate from the laceration the law enforcement officer observed on the child's face in the above investigation. Based on the documentation in the record, the two investigators failed to collaborate and jointly staff the two investigations; this failure limited both investigators' ability to gather and assess information about the safety of Child C in her placement.

But even more confounding, after completing an interview with Child C, during which the investigator observed injuries on the child, the investigator did not conduct any additional investigative activity for more than 16 months. When the investigation resumed on January 23, 2023, the investigator assigned in the record an alleged perpetrator based upon the staff member who was working on the date of the intake report (August 29, 2021) and completed the investigation four days later. As noted above, the investigator observed the child point at a staff member(s) who allegedly hit her, but the record does not clarify the connection between the two and it is not clear the child was hit on the date of the intake report. Before completing and closing the investigation, the investigator did not attempt to interview the alleged perpetrator nor the other individual to whom the child pointed during her interview.

As a result of these substantial deficiencies, the investigator failed to determine whether a staff member hit Child C; and whether a staff member's inadequate supervision allowed a resident to scratch Child C. The investigation demonstrates an egregious example of the State's failure to conduct abuse and neglect investigations in a manner that takes into account at all times the child's safety needs.

Finally, regarding the allegation that Child C was "dirty, had no underwear on, and had feces in her pants" when she arrived at the hospital, PI determined that:

> Health and Human Services Commission (HHSC) Regulatory Services Provider Investigations (PI) will not investigate this matter further. The general complaints regarding [Child C] being unkept do not meet the definition of neglect. This information is being referred back to the provider and, if applicable, forwarded to the appropriate regulatory program, law enforcement, or Office of Inspector General, for appropriate action.[66]

[66] Neglect by a direct provider of an individual in this setting is defined as "a negligent act or omission which caused or may have caused physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death. (b) Examples of neglect may include, but are not limited to, the failure to: (1) establish or carry out an appropriate individual program plan or treatment plan for a specific individual receiving services, if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death; (2) provide adequate nutrition, clothing, or health care to a specific individual receiving services in a residential or inpatient program if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death; or (3) provide

There is no additional documentation in the record about the resolution of those allegations.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on August 29, 2021. An extension was approved on October 7, 2021, with a documented reason of "Principal interviews are needed as well as documentary evidence." The investigation was delayed without activity from September 2021 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 27, 2023, approved on January 27, 2023, and closed on January 30, 2023.

13. IMPACT Case ID: 48794924

Summary of Key Allegations:

On August 26 and September 1, 2021, one law enforcement officer made two separate reports of abuse and neglect to SWI related to Individual 2, the adult resident discussed above. The reporter's allegations were similar in nature to those captured in the above investigation (IMPACT ID: 48785934; allegations of Physical Abuse by Staff 3 of Individual 2), namely that Staff 3 allegedly hit Individual 2. Additionally, the reporter alleged that Individual 2 did not receive appropriate medical care for injuries allegedly caused by Staff 3. Child C was not named in any of the initial allegations; however, she was added to the investigation as an additional victim during the investigation.

Assigned Priority and Disposition:

Following receipt of the two intake reports, PI initiated a Priority Two Physical Abuse investigation related to Child C by Staff 3, which became its seventh concurrent open investigation into Physical Abuse and/or Neglect of Child C. Due to substantial investigative deficiencies, notably that it was not completed for 17 months after the intake, a disposition of the Physical Abuse allegation related to Child C cannot be determined. The investigator assigned the allegation a disposition of Inconclusive.

Monitors' Review:

Based upon the investigative record, it is unclear why the investigator added Child C as an alleged victim to this investigation. Because the investigator did not document her reason(s) for adding Child C as a victim, the monitoring team was unable to determine the specific allegation of Physical Abuse the investigator surfaced related to Child C. In the absence of this central information, the monitoring team identified this investigation as deficient. Next, the investigator

---

a safe environment for a specific individual receiving services, including the failure to maintain adequate numbers of appropriately trained staff, if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death. (c) In this chapter, when the alleged perpetrator is a direct provider to an individual receiving services from any other service provider, neglect is defined as a negligent act or omission which caused physical or emotional injury or death to an individual receiving services." 26 TEX. ADMIN. CODE §711.19.

used a separate interview of Child C that occurred during a different investigation (IMPACT ID: 48801178, discussed below), similar to her approach in IMPACT ID: 48785934, to document her initial face-to-face contact with Child C for the instant investigation. As noted above, Child C was reportedly unwilling to speak to the investigator about allegations contained in the separate investigation and because the investigator did not interview Child C related to the instant allegation, the investigator did not gather any information about it. Next, when the investigator interviewed the alleged perpetrator 16 months after the investigation began, the investigator did not document whether she asked the alleged perpetrator any questions related to Child C. The investigator's interviews with other collateral staff members also did not discuss any allegations related to Child C. As such, the basis for the investigator's finding of Inconclusive for the allegation of Physical Abuse of Child C is unknown.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on August 26, 2021. An extension was approved on October 7, 2021, with a documented reason of "Principal interviews are needed as well as documentary evidence." The investigation was delayed without activity from September 2021 to October 2022. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on February 7, 2023, approved on February 7, 2023, and closed on March 24, 2023.

14. IMPACT Case ID: 48801178

Summary of Key Allegations:

On September 1, 2021, a law enforcement officer reported that Individual 2 and Child C reported that at an unknown time during the night, a named staff member locked them in a bedroom and left the HCS Group Home. Individual 2 was allegedly able to break the bedroom door in half and exited the home with Child C. They then went to a neighbor's home and called 911. The officer reported that 911 received the call at 3:29 a.m. and law enforcement arrived at the home at approximately 4:00 a.m. At that time, according to law enforcement, no staff members were present in the home nor did they observe any posting or other information to inform law enforcement who to contact regarding Individual 2 and Child C's care. Also on September 1, 2021, a different law enforcement officer reported similar allegations about the staff member locking the residents in a bedroom before leaving them in the home. The reporter also stated that the staff member had to leave due to a family emergency and left the home at 3:00 a.m. The staff member allegedly notified another staff member that he needed to leave the premises. Approximately 30 minutes after the officer called in the second report, the officer called in a third report with allegations of Physical Abuse related to Child C and Individual 2. The officer reported that she observed that Child C had multiple bruises and cuts on the top of her eyelids and scratches on her face. Child C reported that Staff 3 punched her in the face and then reportedly stated that other residents "did it." The officer observed that Individual 2 had a cut under her left eye and Individual 2 reported Staff 3 punched her.

Assigned Priority and Disposition:

Following receipt of the three intake reports from law enforcement officers, SWI referred them to PI for a Priority One investigation; PI initiated a Physical Abuse and Neglect investigation related to Child C by two named staff members, Staff 3 and Staff 4. This became its eighth pending investigation into abuse and neglect of Child C in 13 weeks. The investigation into these serious allegations was not completed for 17 months and in one of the more egregious examples of delay the Monitors found, the investigation sat without activity for a full year without explanation. The investigator requested and received an extension to conduct interviews but once granted, did not pursue any additional investigative activity. During that time and as discussed in the investigation below (IMPACT ID: 48846045), PI opened another investigation related to a separate allegation that Staff 3 hit Child C. The investigator assigned the Neglect and Physical Abuse allegations a disposition of Inconclusive. The monitoring team's review of the investigation determined that the allegation of Neglect should have been substantiated with a disposition of Confirmed as related to Staff 4. Regarding the Physical Abuse allegation, due to substantial investigative deficiencies, a disposition cannot be determined.

Monitors' Review:

According to Impact, C3 was a "3 bed person Group Home." The record contains a preponderance of evidence that Staff 4 locked Child C in a bedroom with another adult living at the home and then left the premises. The record showed that Child C was unattended for over two hours during the night, which placed C at risk of physical or emotional injury or death. The Monitors identified the following evidence in support of assigning the allegation of Neglect a disposition of Confirmed.

The police report confirmed Individual 2's allegation that Staff 4 locked Child C and Individual 2 in a bedroom and exited the premises and left them unattended for over two hours. As noted in the police report below, the residents did not have access to a telephone in the home and had to exit the home during the night to access a telephone in a neighbor's home, further exposing the residents to risk of physical or emotional injury. They also did not have access to a bathroom or any means of exit should there have been an emergency. Per the police report:

> Dated: 9/1/21 at 3:29 AM; [address removed] … Upon arrival Officer [name removed] located two females near the roadway at the intersection of S Center St and Motley St. The Females seemed to be in distress and were relieved to see Officers. The females were identified as [Ind. 2 and Child C]. [Ind. 2] stated she was low functioning but stated she was higher functioning than [Child C] who was non-verbal…[Ind. 2] stated she woke up in the middle and found the bedroom door to be locked from the outside. [Ind. 2] stated she yelled out for [Staff 4] who was the caretaker responsible for the overnight shift. [Ind. 2] stated when no one responded she and [Child C] broke the door open to exit the room so [Ind. 2] could use the bathroom. [Ind. 2] stated she and [Child C] searched through the residence and were not able to locate a responsible party or [Staff 4] in the residence. [Ind. 2] stated the front door was left unsecured so she and [Child C] checked the front drive and could not locate anyone outside. [Ind. 2] stated they do not have access to a phone in the house or the ability to call 911 so she went to the neighbor's house at [address removed] to ask them to call… Officers made a sweep of the location and did not locate anyone inside the residence… Officers located the bedroom of [Ind. 2 and Child C]. The door appeared to have been broken in half from the bottom of

> the door. Officers then attempted to contact numerous numbers associated with the group home's management, C3 Christian Academy. Officers were unable to reach anyone.

Additionally, after law enforcement arrived on the scene, it took approximately two hours before a C3 Academy staff member was located and arrived at the home. Based upon the above evidence, the investigative record includes a preponderance of evidence that Staff 4 was negligent when he locked Child C and Individual 2 in a bedroom and left them unattended with no access to an exit, bathroom or means to summon help for over two hours in the night, which placed Child C at risk of physical or emotional injury or death.

Moreover, in light of the allegations that a staff member locked two people living in the home in a room and departed in the middle of the night and that a staff member was deployed to the location only after law enforcement was able to make contact with a person at C3, it is confounding that the investigator failed to consider whether administrators at C3 Academy failed to "provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff" resulting in or creating risk of physical or emotional injury or death for this child.[67] Finally, the investigator did not consider highly relevant information about whether there were similar allegations suggesting a lack of appropriately trained staff at the facility;[68] as noted previously, a review of a site's referral history is not part of PI's practice unless it involves the same alleged perpetrator or victim.

Regarding the Physical Abuse allegation, the investigator did not adequately investigate whether Staff 3 hit Child C causing injury to her face. When interviewed by the investigator, Child C reported that she did not want to discuss the allegations. The investigator did not document any efforts to accommodate Child C's limited speech and comprehension during the face-to-face interview. Such efforts may have encouraged Child C's participation in the interview and, as discussed previously, two prior PI investigations, initiated on May 24, 2021 and July 19, 2021, indicated use of an ASL interpreter. The investigator also did not document whether she observed any injuries on Child C. During the investigator's interview with Individual 2, the investigator did not ask Individual 2 any questions related to whether Staff 3 hit her or Child C and did not document whether she observed any injuries on Individual 2. Next, the investigator did not interview Staff 3 (the alleged perpetrator for the Physical Abuse allegation) until 16 months after the investigation began. The investigator did not ask Staff 3 any questions related to the allegation of Physical Abuse and the injuries the officer observed on Individual 2 and Child C. Instead, the investigator asked Staff 3 questions related to the allegations that Staff 4 locked Child C in the room with an adult also living at the home. The investigator was unable to locate Staff 4 for an interview and at the time he attempted to do so 16 months after the investigation began, according to C3, he was no longer employed there.

Finally, one day after Staff 4 locked Child C and Individual 2 in a bedroom, law enforcement returned to the group home to conduct a welfare check. According to the police report, "While on scene, medics assessed [Child C] as she complained of not feeling well. [Child C's] heart rate and blood pressure vitals were elevated to the point that medics determined she needed to go to the hospital." The investigator did not question any administrators nor staff members regarding Child

[67] *See* 26 TEX. ADMIN. CODE §711.719(b)(3).
[68] *See e.g.*, DFPS, *Preponderance of the Evidence*, 1, 5 (undated training manual) (on file with the Monitors).

C's admittance to a hospital for medical reasons nor did the investigator appear to consider whether Child C's medical issues were related to the serious allegations discussed above.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on September 1, 2021. An extension was approved on November 1, 2021, with a documented reason of "Need more interviews." The investigation was delayed without activity from September 2021 to October 2022. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on February 7, 2023, approved on February 7, 2023, and closed on April 13, 2023.

15. IMPACT Case ID: 48846045

Summary of Key Allegations:

One month after it was alleged that Staff 4 locked Child C in a room at night with another adult living in the home and left the premises, on October 2, 2021, a law enforcement officer reported allegations of Physical Abuse and Neglect of Child C at her placement. The reporter stated that a staff member at the home contacted 911 to report Child C as a runaway. A law enforcement officer reportedly located Child C approximately a mile and a half from the home; she was walking down a busy street with her shirt off. According to the reporter, at the time Child C eloped, a staff member was spoon feeding another resident who used a wheelchair. When law enforcement located the child, she was reportedly happy to see the officer. The reporter observed that Child C had "speech issues" and was unable enunciate her name or address well. As the reporter and Child C neared the placement, the reporter allegedly observed that Child C's "mood changed" and she became "sad" and was "whimpering." Child C told the officer that Staff 3 hit her; the child demonstrated the hit by making a fist and putting it on her chin. The officer did not observe any injuries on Child C.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect and Physical Abuse investigation of Child C by a named staff member, Staff 3. This was the ninth pending investigation of alleged abuse and neglect of Child C in four months, the third time that the child expressed to a reporter that someone was hitting her at the home, and the second time Child C specified that it was Staff 3 who hit her. And yet, one month after receiving the intake report, HHSC's PI did nothing to investigate these serious allegations and the investigation sat with no activity for over a year. In its investigative findings entered 16 months later, PI entered a disposition of Unconfirmed for the allegation of Neglect and a disposition of Inconclusive for the allegation of Physical Abuse. Due to substantial investigative deficiencies, the dispositions of the Neglect and Physical Abuse allegations related to Child C cannot be determined.

Monitors' Review:

The investigator failed to appropriately investigate the allegations of Neglect and Physical Abuse of Child C by Staff 3. First, despite Child C's outcry to the police officer that Staff 3 hit her in the face, the investigator did not interview her until five days after the receipt of the intake report.[69] During her face-to-face interview, Child C confirmed that at the time she ran away, Staff 3 was caring for another resident, and Child C decided to leave the placement. Child C also reported that Staff 3 hit her with a closed fist on the right side of her face. The investigator documented that Child C did not know when or why Staff 3 hit her, that it was first time Staff 3 hit her and that no one was present at the time. The investigator documented that she observed discoloration on Child C's face; however, she documented that it appeared to be dark skin pigmentation and not a bruise. HHSC provided the Monitors with photos, from which it is difficult to discern whether Child C had a bruise on her right temple or whether it was a spot of dark skin pigmentation. The investigator did not document any efforts to accommodate Child C's limited speech and comprehension during the interview.

Following Child C's disclosure to the investigator that Staff 3 hit her in the face, inexplicably the investigator did not pursue any investigative activity for 16 months and the child remained in the placement. It is unclear from the investigative record whether Staff 3 had access to Child C during this extended timeframe prior to her removal from the placement in April 2022. After this substantial delay, the investigator attempted to contact Staff 3 for an interview. At that time, according to the administrator at C3 Academy, Staff 3 reportedly no longer worked at the home and did not return the investigator's call to schedule an interview.

In addition to failing to interview Staff 3, the investigator also appeared to fail to identify that this was Child C's second allegation of Physical Abuse against Staff 3 and that Individual 2 had also recently made the same allegation. During this investigation, and at a significantly delayed time (January 27, 2023), the investigator documented that the prior case history of the "principals" was reviewed (presumably Staff 3);[70] however, the investigator reported that she did not use the case history because "it was deemed not relevant." The investigator erred when stating that Staff 3's prior case history was not relevant to her consideration of the allegations of Physical Abuse. This conclusion is unreasonable and inappropriate and raises questions regarding whether the required case history review was performed.

Sixteen months after the alleged incident, the investigator interviewed a nurse who reported that she saw Child C daily and assessed her after any incidents, such as if the child ran away from the facility. The nurse reported that she no longer had access to her notes related to Child C, presumably due to the investigator's significant delay interviewing her. Based on her recollection 16 months later, she stated that she did not observe any injuries on Child C that were consistent with being hit or punched in the face during the time around October 2, 2021, when the child eloped from the placement. However, Child C did not provide a date or timeframe for when Staff 3 allegedly hit her and the delay and lack of access to her notes rendered the utility of the nurse's statement limited at best. The investigator also interviewed the law enforcement officer who was

[69] The investigator made a first attempt to interview Child C three days after the receipt of the intake report at the location she attended for treatment services; however, the child was no longer present at that location when the investigator arrived. The investigator did not attempt to interview her at the group home later that day.

[70] Due to its relevance, HHSC PI instructs its investigators to review the case history of the alleged victim and alleged perpetrator at the commencement of all investigations. HHSC, *Provider Investigations Handbook*, §3310 Prior Case History, available at https://www.hhs.texas.gov/handbooks/provider-investigations-handbook/3000-investigation-process.

the reporter; the officer's account was consistent with the initial report of the allegations to SWI, and he again repeated his concern that Child C's demeanor changed in the presence of Staff 3 and that this concerned him.

Notable Gaps in Investigation Timeframe:

The investigation took one year and four months to be completed. The intake was received on October 2, 2021. An extension was approved on November 2, 2021, with a documented reason of "Need to request documentation and police report, talk to Ap." The investigation was delayed without activity from October 2021 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 27, 2023, approved on January 27, 2023, and closed on January 30, 2023.

16. IMPACT Case ID: 48896408

Summary of Key Allegations:

Approximately one month after the above investigation was initiated, on November 7, 2021, a clinical therapist at a hospital reported an allegation of Sexual Abuse of Child C. According to the reporter, Child C locked herself in her room at the C3 Academy group home on the date of the intake report. After an unknown period of time in her room alone, Child C used her hand to break a window and ran away from the home. Once Child C was located (presumably by law enforcement, although the intake report does not specify), she was taken to the hospital for "aggression and running away." While at the hospital, Child C made an outcry that an unnamed staff member forced her to have sex with him and attempted to force Child C to have sex with his girlfriend. Child C reported that the staff member was no longer employed at the home. The child reported that she did not want to return to the home.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority One investigation, PI initiated a Sexual Abuse investigation of Child C by an unnamed staff member. This became the tenth pending investigation into allegations of abuse or neglect of Child C while placed at C3 Academy. This investigation evidenced one of the more egregious and confounding failures by PI to conduct its investigation in a manner consistent with the child's safety needs. Due to a dangerous delay and an utter disregard for child safety by the State, a disposition of the Sexual Abuse allegation related to Child C cannot be determined. The investigator assigned the allegation a disposition of Inconclusive.

Monitors' Review:

When the investigator attempted to conduct a timely, face-to-face interview of Child C at a hospital, a registered nurse requested that the investigator not speak with Child C due to difficult behaviors she had reportedly exhibited at the hospital; the investigator agreed to not speak with the child. It is unclear from the investigative record whether the investigator observed Child C at the hospital.

Ten days later, the investigator contacted a Children's Advocacy Center (CAC) to schedule a forensic interview of Child C in response to her allegation of Sexual Abuse. The CAC informed the investigator that only a law enforcement officer or detective who was assigned to Child C's case could request a forensic interview of a child. The investigator did not document any other efforts to secure a forensic interview. As a result, Child C did not participate in a forensic interview with a skilled interviewer who was competent in speaking with children who report allegations of Sexual Abuse.

Over the next 12 months, the investigator did not pursue any investigative activity into the Sexual Abuse allegations, despite the seriousness of Child C's allegation and the failure, up to this point, to interview the child. Notably, during that period of time, one staff member at the group home (Staff 2) was investigated by DFPS's CPI for Sexual Abuse of his stepdaughter and the allegation was substantiated on September 28, 2022. There is nothing in the record indicating that PI had any awareness of the DFPS investigation and substantiation. Nevertheless, finally on November 30, 2022, over a year after the initiation of the investigation while the investigation sat with no documented activity other than an extension, a different investigator attempted to interview Child C. When interviewed face-to-face, Child C allegedly responded to the investigator's questions by shrugging her shoulders or stating that she did not remember the incident. Approximately one month later, in late December 2022, a third investigator interviewed Child C; the interview was not conducted face-to-face, but through a Microsoft TEAMS video call. Child C confirmed over the computer that an unnamed individual sexually abused her. Child C additionally stated that the abuse occurred in a living room and she nodded affirmatively that the unnamed individual's girlfriend was present at the time, as she alleged in the original intake. Child C was reportedly unable or unwilling to provide the name of the alleged perpetrator to the investigator. At the conclusion of the interview, the investigator documented the following: "Investigator ended the interview due to [Child C's] limited speech and lack of response."

Not only did the investigators fail to interview the child for over one year, but when they finally did speak to her, the investigators did not facilitate Child C's participation in the interviews through appropriate accommodations for her limited speech and comprehension, which was fundamental to gathering information about the allegation to support Child C's safety and well-being even after she confirmed the abuse.

Over a year after the investigation began and for the first time, the investigator finally attempted to identify an alleged perpetrator through interviews with administrative staff members at C3 Academy. Both administrators reported to the investigator that Child C had a history of making false allegations of Sexual Abuse. The investigator documented that an administrator stated, "[Child C] would make the same allegations all of the time, against staff and other individuals." But the Monitors' review showed that Child C's investigative history at the placement does not include any prior investigations of Sexual Abuse; therefore, either that statement was untrue or staff members failed to report the prior allegations by the child. The lack of investigative history suggests that, if Child C did make those allegations in the past, staff members did not report Child C's prior allegations of Sexual Abuse to SWI. But the investigator did not question the administrator about this potential failure. (The monitoring team's review found that in many instances, law enforcement officers were the primary reporter of alleged abuse and neglect of Child C that led to the 12 investigations at C3 Academy).

During an interview, one of the administrators provided the investigator with the name of a male staff member (Staff 2) who worked in the HCS home at the time of Child C's allegation one year prior; the investigator added this individual as the alleged perpetrator.[71] Another administrator reported that Staff 2 no longer worked for the home and was presently in jail and "will not be released anytime soon." Five months prior, on June 22, 2022, while this investigation sat without activity, DFPS had received an intake report that Staff 2 sexually abused his stepdaughter and substantiated the allegations on September 28, 2022. When the investigator resumed in November 2022 and Staff 2 had already been substantiated by DFPS for the Sexual Abuse of his stepdaughter, the investigator appeared entirely unaware of these developments. Moreover, in part due to the failure of the investigator to timely identify an alleged perpetrator and conduct this investigation, it appears that Staff 2 had access to all of the residents at the HCS home, including Child C for some period of time.[72]

In addition to the substantiation of Sexual Abuse, Staff 2's investigative history includes one other investigation with allegations of Sexual Abuse from November 2018 while employed by C3 Academy. In that investigation, a young woman resident at the home alleged that Staff 2 masturbated while she was showering. PI assigned a finding of Unconfirmed to the allegation. But the investigator failed to review or discuss both the substantiation for Sexual Abuse by DFPS and the alleged Sexual Abuse allegation investigated by PI during Staff 2's employment at C3 Academy. When the investigator finally interviewed Staff 2 at a county jail 13 months after the investigation began, the alleged perpetrator denied the allegation that he sexually abused Child C. The investigator documented that Staff 2 was in jail due to alleged sexual abuse of his stepdaughter.

The investigator did not interview any other staff members or residents who may have had information related to Child C's allegation. When the investigator asked one of the administrators to provide the names of other residents who lived in the home at the same time as Child C one year prior, the administrator reported that she did not remember their names and when the investigator followed up for records of their names, there is no documentation indicating that she ever received it from the administrator. The administrator also did not appear to respond to the investigator's requests for documents one year after the investigation began, such as timesheets, Staff 2's employment application, names and numbers of other residents, and Child C's incident reports and hospital records.[73] The investigator did not appear to ask Child C the names of other staff members or residents. More critically, the investigator did not review any of Child C's nine prior investigations, all of which occurred in close proximity to these allegations and included names and contact information of other residents and staff members who lived or worked in the home during that time period.

[71] The investigator did not document whether she asked the administrator whether there were any other males who worked at the home at the time of the allegation. The monitoring team's reviews showed that multiple males worked in the HCS home while Child C was a resident; it is unknown why these individuals were not considered by the investigator. Lastly, while the investigator documented that Staff 2 was the alleged perpetrator in the investigative record, the investigator did not formally assign Staff 2 as the alleged perpetrator in IMPACT. As such, the alleged perpetrator for this case is documented as unknown in IMPACT.

[72] Child C was discharged from C3 Academy in May 2022.

[73] The monitoring team was unable to locate any documentation in NeuDocs for this investigation.

Due to these critical deficiencies and the neglectful manner with which this investigation was conducted, the monitoring team was unable to determine an appropriate disposition for the allegation of Sexual Abuse of Child C.

Notable Gaps in Investigation Timeframe:

The investigation took one year and one month to be completed. The intake was received on November 7, 2021. An extension was approved on December 10, 2021, with a documented reason of "Extraordinary Circumstances." The investigation was delayed without activity from November 2021 to November 2022. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on December 21, 2022, approved on December 21, 2022, and closed on December 23, 2022.

17. IMPACT Case ID: 49096014

Summary of Key Allegations:

On April 6, 2022, five months after PI opened the above investigation involving allegations of Sexual Abuse of Child C, an OCOK caseworker reported an allegation of Physical Abuse of Child C at C3 Academy. The reporter alleged that a staff member (Staff 5) hit Child C on the leg with a cord because she was allegedly behaving "bad." The caseworker reported that Child C had a thin bruise on her left thigh that was about two inches long. Seven days later, on April 13, 2022, school personnel reported that Child C stated that she did not want to return to C3 Academy because she was being abused there. The reporter stated that a school nurse observed Child C with circular bruises on the front of her thigh, noting that one bruise was approximately two inches in length. The reporter stated that Child C said the injury occurred in the group home, but Child C did not provide the name of the individual who allegedly hit her.

Assigned Priority and Disposition:

Following receipt of the two intake reports, which SWI referred for a Priority Two investigation, PI initiated a Physical Abuse investigation of Child C by a named staff member (Staff 5). This became the eleventh pending investigation into allegations of abuse or neglect of Child C while placed with C3 Academy and the sixth allegation of Physical Abuse. In a failure to prioritize Child C's safety, the investigation had a nine-month delay in investigative activity, despite Child C's confirmation of her allegation of Physical Abuse. Due to substantial investigative deficiencies, a disposition of the allegation cannot be determined, despite the investigator's assignment of a disposition of Inconclusive.

Monitors' Review:

Due to significantly delayed and missing interviews, the investigator failed to gather sufficient information to determine whether Staff 5 physically abused Child C. Nine days after SWI received the first intake report, the investigator interviewed Child C, who maintained her original

allegation.[74] She stated to the investigator that on an unknown date, she went in the bathroom at C3 Academy and hit her head on the wall; after Staff 5 heard Child C hit her head, Child C stated that Staff 5 entered the bathroom and hit her with a white cord on her leg. Child C stated that no one observed the incident. According to the investigator, Child C did not allow her to observe whether she had any bruising nor photograph her.

Despite Child C's confirmation of her allegation of Physical Abuse by Staff 5, the investigator did not conduct any investigative activity for nine months, a clear disregard for the child's safety. Based on the investigative record, it is unclear whether Staff 5 continued to work and have access to residents at C3 Academy during this significant lapse in investigative activity. Nine months after Child C's interview and when Child C was no longer placed at the group home, the investigator first attempted to contact Staff 5. At that point, Staff 5 reportedly no longer worked at C3 Academy and did not respond to the investigator's late attempt for an interview. In the absence of this key interview with Staff 5, the investigator did not attempt to interview collateral staff members nor residents to gather information about the allegation. When the investigator interviewed the reporters (school personnel and caseworker), they consistently reported that Child C disclosed to them nine months prior that a staff member hit her with a cord and they observed a bruise on Child C's leg, though it was unclear to the reporters whether the bruise was new or old when they observed it. Despite Child C's consistent outcry to both reporters and the investigator that Staff 5 hit her with a cord, the investigator assigned a disposition of Inconclusive to the allegation of Physical Abuse by Staff 5.

Notable Gaps in Investigation Timeframe:

The investigation took nearly ten months to be completed. The intake was received on April 6, 2022. An extension was approved on May 11, 2022 with a documented reason of "Extraordinary Circumstances." A second extension was approved on August 16, 2022, again with a documented reason of "Extraordinary Circumstances." The investigation was delayed without activity from April 2022 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 27, 2023, approved on January 27, 2023, and closed on January 30, 2023.

18. IMPACT Case ID: 49131249

Summary of Key Allegations:

On April 28, 2022, Child C's caseworker reported an allegation of Physical Abuse of Child C at C3 Academy. The caseworker reported that on the date of the intake report hospital staff notified her that an unnamed staff member dropped Child C off at the hospital. The unnamed staff member reported to the hospital that Child C had been restrained at the group home; the staff member reportedly did not provide any other information to the hospital before departing and no one stayed with the child at the hospital. While at the hospital, medical personnel determined that Child C had a fractured jaw, which required surgery. The reporter stated that it was unclear how or when Child

[74] The investigator attempted a timely face-to-face interview with Child C; however, the attempt was unsuccessful because no one at the group home allegedly opened the door to the investigator. The investigator did not attempt to interview Child C again until nine days after the date of the first intake report.

C was injured. One day later, on April 29, 2022, medical personnel from the hospital reported that Child C had a fractured mandible (lower jaw) in two places and Child C was unable to explain how she was injured.

Assigned Priority and Disposition:

Following receipt of the two intake reports, which SWI referred for a Priority One investigation, PI initiated a Physical Abuse investigation of Child C by a named staff member, Staff 6. This investigation became the twelfth pending concurrent investigation of abuse and neglect of Child C at C3 and the seventh allegation of Physical Abuse. The allegation of Physical Abuse should have been substantiated with a disposition of Confirmed. The disposition of Inconclusive assigned by PI nine months after the investigation was initiated is inappropriate, and the investigation was conducted with an utter disregard for child safety.

Monitors' Review:

Despite a delayed and deficient investigation, the Monitors found that the record contains a preponderance of evidence that Staff 6 hit Child C, causing substantial injury to the child by fracturing her jaw. The Monitors identified the following evidence in support of assigning the allegation of Physical Abuse with a disposition of Confirmed:

- Medical personnel reported that Child C was diagnosed with a fractured jaw in two places after a C3 staff member dropped the child off at the hospital;

- When the investigator asked Child C what Staff 6 "did to her," Child C "clearly stated" that Staff 6 hit her; and,

- An administrator of C3 Academy, who was interviewed six months after the intake, reported that another resident[75] informed her that she observed Staff 6 hit Child C in the face with his fist multiple times the day before the child was taken to the hospital. According to the administrator, after the child was physically abused by Staff 6, presumably the only staff member on-duty for that evening's shift, Child C reportedly went to bed with untreated and substantial injuries. The following day, a different staff member and the administrator observed blood and bruising on Child C's face. At this time, the administrator instructed a staff member to transport the child to a hospital and the administrator reportedly notified law enforcement. The Monitors were not able to locate any documentation confirming that anyone at C3 notified SWI of the critical incident of abuse and the investigator did not attempt to corroborate the administrator's claim that the group home notified law enforcement. The administrator reported that Staff 6 was immediately terminated.

Based upon the above evidence, the investigative record contains a preponderance of evidence that Staff 6 used inappropriate and excessive force when he hit Child C and fractured her jaw in two

[75] Because C3 Academy did not comply with the investigator's request for the witness's contact information, the investigator did not interview the witness. It is unclear whether the investigator could have obtained the witness's contact information independent of C3 Academy. C3 Academy also failed to comply with the investigator's request for other documentation related to Child C and the allegations.

places. At the time of this incident, PI's investigation of the Physical Abuse of Child C with a taser remained open for four more months until it was finally Confirmed in October 2022.

The monitoring team's review identified that on February 24, 2022, two months prior to Staff 6 hitting and significantly injuring Child C, PI initiated a separate investigation (IMPACT ID: 49038369) involving allegations that Staff 6 physically abused an adult resident at the group home.[76] Because PI did not conduct a timely or adequate investigation of the Physical Abuse allegation related to the adult resident, Staff 6 continued to work at the group home and two months later was able to physically assault Child C.

As noted above, the monitoring team found that the investigation of Staff 6's Physical Abuse of Child C was again significantly delayed and deficient, which is particularly egregious given the severity of the incident of Physical Abuse suffered by Child C. In addition to conducting delayed interviews with key individuals six months after the investigation began, the investigator did not investigate the following allegations of Neglect made by the child's caseworker during the investigation. These allegations raised significant concern for the safety and well-being of the residents placed at C3 Academy.

- The OCOK caseworker reported that when law enforcement arrived at the group home a few hours after Child C arrived at the hospital, "C3 Academy had completely cleaned out the house." The investigator did not appear to ask the caseworker to provide any clarifying detail to explain her statement that the group home had "completely cleaned house." The investigator also did not attempt to contact the responding police station for eight months after the investigation began to request information, such as a police report, which may have provided additional information regarding the caseworker's statement. The investigative record did not include a police report.

- The OCOK caseworker reported that when law enforcement arrived at the group home they observed that one on-duty staff member had an ankle monitor and was reportedly "out on bond for felony stalking" and another on-duty staff member was a registered sex offender.[77] The investigator made no attempts to identify the names of these staff members, to determine whether they continued to be employed at C3 Academy and had access to residents, nor to corroborate or explore the information about the staff members' alleged criminal charges. The investigator only documented in her findings that "It is a concern that the agency is employing registered sex offenders." The investigator did not appear to take any action regarding this serious safety concern, another egregious failure to conduct the investigation in a manner consistent with child safety at all times that

[76] The investigation (IMPACT ID: 49038369) of Staff 6 was initiated on February 24, 2022 in response to, among other allegations, a law enforcement officer's report to SWI that he observed that an adult resident of C3 Academy had a bruise under his left eye. During the adult resident's interview with a PI investigator on February 25, 2022, the individual reported that he thought Staff 6 tried to hit him, that Staff 6 was mean to him "over little stuff," and that Staff 6 told the individual to "Get your ass to bed." The investigator's photograph of the adult showed bruising under his eye. Following this interview and clear indication of risk related to Staff 6, the investigator did not pursue any investigative activity for 14 months. At this delayed time, the investigator attempted to interview, among other individuals, Staff 6. Staff 6 did not respond to the investigator's attempts for an interview. Shortly thereafter, the investigator closed the deficient investigation with a finding of Inconclusive for the allegation of Physical Abuse.

[77] Due to investigative failures, it is unclear whether the staff member that the OCOK caseworker stated was a registered sex offender was Staff 2, who was reportedly incarcerated for sexually assaulting a minor, as discussed in investigation IMPACT ID: 48896408.

reflected a shocking disregard of children's safety.

- The OCOK caseworker reported that C3 Academy terminates staff members after allegations of abuse or neglect are made against them; however, the group home will then hire these same staff back after an investigation has closed. The investigator did not investigate this allegation and did not appear to discover evidence that, in this instance, it was not accurate.

- The OCOK caseworker reported that C3 Academy did not provide her with any of Child C's paperwork, medications, or belongings after Child C left the placement. The caseworker reported that she threatened to call law enforcement in order for the group home to provide Child C's medications, which she ultimately received. The group home never provided Child C's belongings or paperwork.

- The OCOK caseworker reported in her intake report that according to hospital personnel, a staff member from C3 Academy dropped the child off at the hospital and departed without providing additional information on behalf of the child, leaving the child alone. She also indicated that she learned of the child's status through hospital personnel, as opposed to notification from anyone at the placement. The investigative record failed to clarify or confirm the duration of time C3 Academy left the child alone at the hospital with a fractured jaw nor whether anyone attempted to notify the caseworker or law guardian.

Due to serious and ongoing safety concerns that appeared to have gone unaddressed by HHSC and PI, a detective for the local police department reported to the investigator that the department was presently attempting to "shut down" C3 Academy. Following the detective's statement to the investigator, the investigator did not document that she took any additional action to safeguard the children and adults still placed at C3 Academy.

This egregious incident of Physical Abuse occurred nearly one year after a different staff member tasered Child C, seven months after another staff member locked Child C in a bedroom and left the group home location, and five months after her outcry of sexual abuse, among other serious allegations; and yet, once again, the investigator failed to consider or discuss whether administrators at C3 were neglectful, particularly for a failure to "provide a safe environment for [Child C], including the failure to maintain adequate numbers of appropriately trained staff, if such failure results in physical or emotional injury or death to [Child C] or which placed [Child C] at risk of physical or emotional injury or death."[78]

Child C did not return to C3 Academy after she was hospitalized for a fractured jaw.

Notable Gaps in Investigation Timeframe:

The investigation took nine months to be completed. The intake was received on April 28, 2022. An extension was approved on June 8, 2022, with a documented reason of "Extraordinary Circumstances." The investigation was delayed without activity from May 2022 to November 2022. The record did not include any explanation for the lack of investigative activity and

[78] *See* 26 TEX. ADMIN. CODE §711.719(b)(3).

substantial delay in completing the investigation. The investigation was completed on February 7, 2023, approved on February 7, 2023, and closed on April 13, 2023.

Child D, age 15, IQ of 47

The monitoring team reviewed three PI abuse or neglect investigations with a disposition of Unconfirmed that involved a child (Child D, age 15) while he was placed at Exceptional Employment Service, an HCS Group Home. Child D is diagnosed with the following: autism spectrum disorder; Moderate Intellectual Disabilities; Speech Impairment; Attention-Deficit/Hyperactivity Disorder; Urinary Incontinence; and Mitochondrial Metabolic disease, which causes gastrointestinal and respiratory problems. Due to Child D's low IQ of 47 and behavioral and mental health needs, he was eligible for and enrolled in the HCS waiver program and was placed at the HCS Group Home from April 23, 2018 until present. As discussed below, the monitoring team's review found that PI inadequately conducted the following three abuse or neglect investigations involving Child D while he was placed at Exceptional Employment Service.

19. IMPACT Case ID: 48870997

Summary of Key Allegations:

On October 20, 2021, a law enforcement officer reported an allegation of Neglect of a child (age 13 and not in DFPS care) at Exceptional Employment Service. The reporter stated that the child was located by a member of the community after running away from the facility. The reporter alleged that "[t]his [was] not the first or second time a special needs child ran away or escaped" from the group home.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect investigation related to the child who was not in DFPS care. During the investigation and nearly four months after receiving the intake, the investigator added two PMC children (Child D, age 15 and Child E, age 15) to the investigative record as alleged victims due to the nature of the allegations; Child D and Child E lived in the home at the time of the incident. Due to substantial investigative deficiencies, most notably that it took 15 months to complete the investigation, a disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed for both Child D and Child E.

Monitors' Review:

This investigation is deficient due to significant investigative delays, including a four-month delay in speaking to the alleged victims, a failure to conduct face-to-face interviews with the alleged victims, and a missing interview with the alleged perpetrator. Approximately four months after the investigation was initiated, the investigator interviewed a collateral staff member who reported that Child D and Child E lived in the home at the time of the alleged incident. The investigator had not previously identified the other residents who lived in the home at the time the primary victim ran away. At this delayed time, the investigator attempted to conduct telephone interviews with both Child D and Child E, despite the HCS Group Home's house manager reporting to the